MEDI-CAL HEALTH CARE PROGRAM UPDATE

January 14, 2004

CHDP - Preventive Care for Better Health

CHDP provides free health care assessments and dental exams to Medi-Cal recipients under age 21. Services include, but are not limited to, complete physical exams, oral health assessment, immunizations, hearing and visual screening. A CHDP assessment may identify health care problems that can be treated to prevent conditions that, if left untreated, may become permanently disabling. Children with suspected health problems are then referred for diagnosis and treatment. Your role in raising awareness of the CHDP program is vital. When you have contact with a Medi-Cal beneficiary who has children, under age 21, take a few moments to encourage them to have their children participate in this important program for promoting good health in our children.

Reference: Title 22, Section 50184 Referral for Social Services

Disclosure of Medical/Personal Information

Under the Health Insurance Portability and Accountability Act (HIPAA), a person's protected health information cannot be shared without their signed authorization (See DPSS Forms Manual Letter 4478 dated 8/14/03 for release of the MC 220 04/03 Authorization for Release of Information.)

However, these provisions do not affect previous rules of confidentiality as regards the sharing of information with the Department of Health Services (DHS) when necessary to establish or determine eligibility. A signed authorization **is not required** to respond to questions from Patient Financial Services or other representatives from DHS regarding applicant/recipient information on file. As a general rule, case information may be released without authorization only for purposes directly connected with the administration of public social services. Public social services are defined as aid or services administered or supervised by the California Department of Social Services (CDSS) or CDHS. (Ref. 19-004.1 Release of Confidential Information) A signed authorization is still required to release personal information to others not under the supervision of these departments. ACWDL 03-18 dated 4-21-03 Subject: Medi-Cal Health Insurance Portability and Accountability Act Notice of Privacy Practices and 00-66 dated 12-18-00 Instructions for HIPAA '96.

PUBLISHED BY:
The Los Angeles County
Department of Public Social Services
Bureau of Special Operations

Adding Other Family Members

This is to remind District eligibility staff of the procedures of adding other family members for Medi-Cal. To add other family members when the last form on file is the MC 321 HFP Joint Mail-In Application, the following must be completed:

- MC 321 HFP-AP (Supplement)
- MC 322 (Property form)
- MC 13
- CA 2.1 and CA 2.1 Q
- Identity verification for one adult

Please note that the supplemental application is not required if an MC 210 is on file because the parents information should already be included on this application. Therefore, the only form needed in this case is MC 13.

Ref: Administrative Directive #4104, dated March 12, 2001

PRUCOL

Permanently **R**esiding **U**nder **C**olor **O**f **L**aw (PRUCOL) status is available to ALL Medi-Cal beneficiaries who wish to claim it. It is NOT just for persons in long-term care or who are renal dialysis. (MPIH 50301.2)

Aged & Disabled Program

Effective 1/1/04 the A&D deduction for a couple has been increased to $389. The deduction for a single person is unchanged.

Additional adjustments are expected in April when the Federal Poverty Levels increase.

Express Enrollment

Express Enrollment is a new Medi-Cal referral process which allows LAUSD and DPSS staff to enroll uninsured students into Medi-Cal using the National School Lunch Program (NSLP) application (facsimile on reverse).

The one-year pilot began in August of this year. As of December 10th, our Department received 2,250 applications and enrolled 776 children into temporary full-scope Medi-Cal in Aid Code "7T" based on the school lunch application and the screening completed by LAUSD staff.

The school lunch application (see the reverse side) will be used in lieu of the MC 210 for children applying through the Express Enrollment process. This application in conjunction with the MC 368 shall be viewed and accepted by eligibility staff as valid Medi-Cal applications.

Reference: ACWL 03-35 dated, July 23, 2003

LOS ANGELES UNIFIED SCHOOL DISTRICT

2003-2004 Application for Meal Benefits

TRACK____ ROOV#____
FORM: E 104411

Please complete and return this application to the school cafeteria. If you need help completing this form, call the District's toll-free Helpline 1(866) 742-2273. Completing items marked with ** and **STEP 6** is optional and not required to apply for free or reduced-price meals. However, if you complete the optional items, your child may be eligible to receive health coverage under the Medi-Cal program.

STEP 1 ENTER THE STUDENT'S NAME AND PROVIDE ALL REQUIRED INFORMATION. Print CAPITAL LETTERS with a Ballpoint Pen.

Student's Last Name | Student's First Name | Mid. Init.

Date of Birth** (MM-DD-YY) | Gender: Mark (X) Male / Female | Grade | Student's Monthly Income | School Name

STEP 2 IF THIS CHILD IS A FOSTER CHILD, enter child's persona MONTHLY INCOME $ .00 and Skip to STEP 5.*

*NOTE: If STEP 2 or STEP 3 are applicable for this child, the adult's social security number is not required with adult household member's signature in STEP 5.

STEP 3 IF THIS CHILD RECEIVES FOOD STAMPS, CalWORKs, FDPIR, or Kin-CAP BENEFITS, enter child's CASE NUMBER and Skip to STEP 5.*

STEP 4 ALL OTHER HOUSEHOLD MEMBERS. List all other household members, including yourself and any children, whether or not they have income. Indicate the amount and the source of all monthly income each household member received last month. If any amount last month was more or less than usual, enter the usual monthly income. Enter any income received last month *by / for a child (other than applicant child)* from full-time or regular part-time employment, SSI, or Adoption Assistance payments.

Household Members (Last Name, First Name)	Relationship to child named in STEP 1** (EXAMPLES: parent, stepparent, sister, guardian, friend, etc.)	GROSS MONTHLY INCOME FROM ALL SOURCES: Earnings From Work, Before Deductions: Job 1	Welfare Payments, Child Support / Alimony	Pay from Pensions, Retirement, or Social Security	Job 2 or Any Other Income
1		$ .00	$ .00	$ .00	$ .00
2		$ .00	$ .00	$ .00	$ .00
3		$ .00	$ .00	$ .00	$ .00
4		$ .00	$ .00	$ .00	$ .00
5		$ .00	$ .00	$ .00	$ .00
6		$ .00	$ .00	$ .00	$ .00
7		$ .00	$ .00	$ .00	$ .00
8		$ .00	$ .00	$ .00	$ .00
9		$ .00	$ .00	$ .00	$ .00
10		$ .00	$ .00	$ .00	$ .00

If more than 10, please complete and attach additional application forms, or sheets of paper, with their names, relationships, and income information.

STEP 5 READ, COMPLETE, AND SIGN THIS SECTION. I certify that all of the above information is true and correct and that all income is reported. I understand that this information is given for the receipt of Federal funds, that school officials may verify the information on this application, and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature of adult household member completing this application: X | Telephone Number: ( ) - | Date: (MM-DD-YY)

Printed name of adult household member signing this application: | Social Security Number: - - | Or, check (X) here: Does not have a Social Security Number ○

Address: | City: | State: | Zip Code:

STEP 6 MEDI-CAL BENEFITS: *Optional*. If the child named in STEP 1 is eligible for free meals and you complete this section, we will share this meal application with the Medi-Cal program. A Medi-Cal representative will contact you for more information to determine if this child is eligible for benefits. If this child already receives Medi-Cal benefits or you do not want Medi-Cal for this child, do not complete this section. You do not have to complete STEP 6 to apply for or receive free or reduced-price meals. This meal application will not be shared with the Medi-Cal program unless we have your signed consent. If you have any questions, call the District's toll-free Helpline 1(866) 742-2273.

IMPORTANT: Questions on this application that are marked by ** must be answered to determine if this child can receive Medi-Cal benefits.

If you **did not** complete **STEP 4**, please complete the following two items:

- Number of Immediate Family Members Including This Child, Living in Household: ____
- Combined Monthly Income of this Child and Birth / Adoptive Parent(s) Living in Household: $ .00

IF MY CHILD IS ELIGIBLE FOR FREE MEALS, I agree to share the information on this meal application with Medi-Cal representatives for the purpose of applying for Medi-Cal benefits for my child. I understand that the information on this National School Lunch Program application is confidential and will not be shared with any other government agencies, except for the purpose of the administration of the Medi-Cal program. I certify that I am the parent / guardian of the child named on this application. I declare under penalty of perjury under the laws of the State of California that the declarations and information on this application for Medi-Cal purposes are true and correct to the best of my knowledge and belief.

Signature of Parent / Guardian: X | Printed Name of Parent / Guardian signing in section: | Date: (MM-DD-YY)

FOR OFFICE USE ONLY

Categorically Eligible Free: Yes (X) ○ | MI | HS | Free ○ | T 45 ○ | Red ○ | NE ○ | Rev By Init: | Date

Please Return Both Pages To School Cafeteria. Do Not Separate Pages. Thank You.